

## Complete Summary

### GUIDELINE TITLE

When to suspect child maltreatment.

### BIBLIOGRAPHIC SOURCE(S)

National Collaborating Centre for Women's and Children's Health. When to suspect child maltreatment. London (UK): National Institute for Health and Clinical Excellence (NICE); 2009 Dec. 40 p. (Clinical guideline; no. 89).

### GUIDELINE STATUS

This is the current release of the guideline.

## COMPLETE SUMMARY CONTENT

SCOPE  
METHODOLOGY - including Rating Scheme and Cost Analysis  
RECOMMENDATIONS  
EVIDENCE SUPPORTING THE RECOMMENDATIONS  
BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS  
QUALIFYING STATEMENTS  
IMPLEMENTATION OF THE GUIDELINE  
INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT  
CATEGORIES  
IDENTIFYING INFORMATION AND AVAILABILITY  
DISCLAIMER

## SCOPE

### DISEASE/CONDITION(S)

Child maltreatment

*Child maltreatment* includes neglect, physical, sexual, and emotional abuse, and fabricated or induced illness. This guidance uses the definition of child maltreatment as set out in the document "Working together to safeguard children." Available at <http://www.dcsf.gov.uk/>.

**Note:** The following topics were outside the scope of this guideline and have therefore not been covered:

- Risk factors for child maltreatment, which are well recognised. Examples include:
  - Parental or carer drug or alcohol misuse
  - Parental or carer mental health problems

- Intra-familial violence or history of violent offending
- Previous child maltreatment in members of the family
- Known maltreatment of animals by the parent or carer
- Vulnerable and unsupported parents or carers
- Pre-existing disability in the child
- Protection of the unborn child
- Children who have died as a result of child maltreatment
- Diagnostic assessment and investigations (for example, X-rays)
- Treatment and care of the child if maltreatment is suspected
- How healthcare professionals should proceed once they suspect maltreatment
- Healthcare professionals' competency, training, and behaviour
- Service organisation
- Child protection procedures
- Communication of suspicions to parents or carers, or the child or young person
- Education and information for parents or carers, or the child or young person

## **GUIDELINE CATEGORY**

Evaluation  
Management

## **CLINICAL SPECIALTY**

Emergency Medicine  
Family Practice  
Nursing  
Obstetrics and Gynecology  
Pediatrics  
Psychiatry  
Psychology

## **INTENDED USERS**

Advanced Practice Nurses  
Allied Health Personnel  
Emergency Medical Technicians/Paramedics  
Nurses  
Patients  
Physician Assistants  
Physicians  
Psychologists/Non-physician Behavioral Health Clinicians  
Social Workers

## **GUIDELINE OBJECTIVE(S)**

To provide a summary of clinical features associated with child maltreatment (alerting features) that may be observed when a child presents to healthcare professionals

**Note:** When used in routine practice, the guidance should prompt all healthcare professionals to think about the possibility of maltreatment. The guidance is not intended to be a definitive assessment tool nor does it define diagnostic criteria or tests. The guidance is about child protection issues rather than the wider context of safeguarding.

## TARGET POPULATION

Children presenting with physical and psychological symptoms and signs that constitute alerting features of one or more types of maltreatment

This guidance uses the following terms to describe children of different ages:

- Infant (aged under 1 year)
- Child (aged under 13 years)
- Young person (aged 13–17 years)

## INTERVENTIONS AND PRACTICES CONSIDERED

1. Identification or exclusion of child maltreatment by piecing together information from many sources (history, reports, child's appearance, etc.)
2. Seeking an explanation for any injury or presentation
3. Recording what is observed in the clinical record
4. Considering, suspecting, or excluding maltreatment
  - Discussing concerns with other professionals
  - Gathering collateral information from other agencies and health disciplines
  - Ensuring review of child or young person at a date appropriate to the concern
  - Referral of child to children's social care, if maltreatment is suspected
5. Recording all actions taken and the outcome

## MAJOR OUTCOMES CONSIDERED

- Prevalence of child maltreatment
- Probability of child maltreatment based on presenting features

## METHODOLOGY

### METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

### DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

**Note from the National Guideline Clearinghouse (NGC):** This guideline was developed by the National Collaborating Centre for Women's and Children's Health (NCC-WCH) on behalf of the National Institute for Health and Clinical Excellence (NICE). See the "Availability of Companion Documents" field for the full version of this guidance.

#### Literature Search Strategy

Initial scoping searches were executed to identify relevant guidelines (local, national, and international) produced by other development groups. The Royal College of Paediatrics and Child Health (RCPCH) document *The Physical Signs of*

*Child Sexual Abuse*, the Health Technology Assessment (HTA) 'Performance of screening tests for child physical abuse in accident and emergency departments' and systematic reviews by the Welsh Child Protection Systematic Review Group were referred to, with permission.

Relevant published evidence to inform the guideline development process and answer the clinical questions was identified by systematic search strategies, unless recent high-quality systematic reviews had been identified. Additionally, stakeholder organisations were invited to submit evidence for consideration by the Guideline Development Group (GDG) provided it was relevant to the clinical questions and of equivalent or better quality than evidence identified by the search strategies.

Systematic searches to answer the clinical questions formulated and agreed by the GDG were executed using the following databases via the OVID platform: Medline (1950 onwards), Embase (1980 onwards), Cumulative Index to Nursing and Allied Health Literature (1982 onwards), PsycINFO (1967 onwards), Cochrane Central Register of Controlled Trials (3rd Quarter 2007), Cochrane Database of Systematic Reviews (3rd Quarter 2007), and Database of Abstracts of Reviews of Effects (3rd Quarter 2007).

Search strategies combined relevant controlled vocabulary and natural language in an effort to balance sensitivity and specificity. Unless advised by the GDG, searches were not date-specific. Language restrictions were applied to searches and searches were limited to English language results. Both generic and specially developed methodological search filters were used appropriately.

There was no systematic attempt to search grey literature (conferences, abstracts, theses, and unpublished trials). Hand searching of journals not indexed on the databases was not undertaken.

At the end of the guideline development process, searches were updated and re-executed, thereby including evidence published and included in the databases up to 5 September 2008. Any literature published after this date was not included. This date should be considered the starting point for searching for new literature for future updates to this guidance.

Further details of the search strategies, including the methodological filters employed, are provided in separate files on the NICE website (see "Availability of Companion Documents" field).

## **NUMBER OF SOURCE DOCUMENTS**

Not stated

## **METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE**

Expert Consensus

Weighting According to a Rating Scheme (Scheme Given)

## RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

### Levels of Evidence for Intervention Studies

Level	Source of Evidence
<b>1++</b>	High-quality meta-analyses, systematic reviews of randomised controlled trials (RCTs), or RCTs with a very low risk of bias
<b>1+</b>	Well-conducted meta-analyses, systematic reviews of RCTs, or RCTs with a low risk of bias
<b>1–</b>	Meta-analysis, systematic reviews of RCTs, or RCTs with a high risk of bias
<b>2++</b>	High-quality systematic reviews of case-control or cohort studies; high-quality case-control or cohort studies with a very low risk of confounding, bias or chance and a high probability that the relationship is causal
<b>2+</b>	Well-conducted case-control or cohort studies with a low risk of confounding, bias, or chance and a moderate probability that the relationship is causal
<b>2–</b>	Case-control or cohort studies with a high risk of confounding, bias, or chance and a significant risk that the relationship is not causal
<b>3</b>	Non-analytical studies (e.g., case reports, case series)
<b>4</b>	Expert opinion, formal consensus

## METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses  
Systematic Review with Evidence Tables

## DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

**Note from the National Guideline Clearinghouse (NGC):** This guideline was developed by the National Collaborating Centre for Women's and Children's Health (NCC-WCH) on behalf of the National Institute for Health and Clinical Excellence (NICE). See the "Availability of Companion Documents" field for the full version of this guidance.

### Synthesis of Clinical Evidence

Clinical evidence was reviewed using established guides and classified using the established hierarchical system shown in "Rating Scheme for the Strength of the Evidence." This system reflects the susceptibility to bias that is inherent in particular study designs.

The type of clinical question dictates the highest level of evidence that may be sought. In assessing the quality of the evidence, each study receives a quality rating coded as '++', '+', or '–'. For issues of therapy or treatment, the highest possible evidence level (EL) is a well-conducted systematic review or meta-analysis of randomised controlled trials (RCTs; EL = 1++) or an individual RCT (EL = 1+). As therapeutic interventions were not part of the scope, no

randomised controlled trials were reviewed. Studies of poor quality are rated as '-'. Usually, studies rated as '-' should not be used as a basis for making a recommendation, but they can be used to inform recommendations.

For each clinical question, the highest available level of evidence was selected. Where appropriate, for example if a systematic review or meta-analysis existed in relation to a question, studies of a weaker design were not included. Where systematic reviews or meta-analyses did not exist, comparative studies and large case series (comprising data on more than 50 children) were sought.

Evidence was synthesised qualitatively by summarising the content of identified papers in evidence tables and agreeing brief statements that accurately reflected the evidence.

Summary results and data are presented in the text. More detailed results and data are presented in the evidence tables provided on the NICE website. Where possible, dichotomous outcomes are presented as relative risks (RRs) with 95% confidence intervals (CIs), and continuous outcomes are presented as mean differences with 95% CIs or standard deviations (SDs).

## **METHODS USED TO FORMULATE THE RECOMMENDATIONS**

Expert Consensus (Delphi)  
Informal Consensus

## **DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS**

**Note from the National Guideline Clearinghouse (NGC):** This guideline was developed by the National Collaborating Centre for Women's and Children's Health (NCC-WCH) on behalf of the National Institute for Health and Clinical Excellence (NICE). See the "Availability of Companion Documents" field for the full version of this guidance.

### **The Guideline Development Group (GDG)**

The GDG consisted of one child and adolescent psychiatrist, two general practitioners (GPs), two nurses/health visitors, one child psychologist, one accident and emergency consultant, three consultant community pediatricians, one consultant hospital pediatrician, one social worker, and four patient/consumer members.

All committee members were recruited because of their expertise in child protection.

Staff from the NCC-WCH provided methodological support for the guidance development process, undertook systematic searches, retrieved and appraised the evidence, and wrote successive drafts of the guidance. A clinical adviser with expertise in child protection and the related evidence base was recruited to support the technical team.

## **Guideline Development Methodology**

This guidance was commissioned by NICE and developed in accordance with the guideline development process outlined in the NICE *Guidelines Manual*.

In accordance with NICE's Equality Scheme, ethnic and cultural considerations and factors relating to disabilities have been considered by the GDG throughout the development process and specifically addressed in individual recommendations where relevant. Further information is available from: [www.nice.org.uk/aboutnice/howwework/NICEEqualityScheme.jsp](http://www.nice.org.uk/aboutnice/howwework/NICEEqualityScheme.jsp).

## **Forming Clinical Questions**

The GDG identified a list of features that were thought to be signs or symptoms of maltreatment. The list was refined based on relevance to the healthcare setting (see Appendix B in the full version of the original guideline [see the "Availability of Companion Documents" field]). The standard clinical question was 'when is feature X a reason to suspect child maltreatment?' It should be noted that clinical features that do not appear in this guidance may be indicators of maltreatment nonetheless.

## **Delphi Consensus**

A two-round modified Delphi consensus process was used to derive recommendations in some areas (see Appendix C of the full version of the original guideline). These areas were defined by:

- There being a lack of relevant literature on a clinical feature's importance in child maltreatment
- The GDG being unable to reach a congruent opinion
- The GDG requiring external validation from a wider group of experts (the Delphi panel) for their opinion

There were some areas where the evidence base was sparse but the GDG was able to reach internal consensus.

The Delphi panel comprised child protection experts (clinicians with significant experience in child protection). There were 95 respondents to Round 1 of the survey and their affiliations are as follows (see Appendix C of the full version of the original guideline [see the "Availability of Companion Documents" field] for information on the recruitment processes):

- 30 paediatricians (including 13 named/designated doctors for child protection/safeguarding children)
- 15 nurses (including 14 named/designated nurses for child protection/safeguarding children)
- Three GPs (one child protection adviser for GPs)
- One genito-urinary medicine physician
- Seven health visitors
- Four dentists (including one named dentist from a safeguarding children board)

- Three psychotherapists
- Three forensic physicians
- 11 psychiatrists
- 13 psychologists (including two clinical leads for Child and Adolescent Mental Health Services [CAMHS])
- One gastroenterologist
- One social services representative
- Two academics
- One other

## **Forming Recommendations**

For each clinical question, recommendations were derived using, and explicitly linked to, the evidence that supported them. In the first instance, informal consensus methods were used by the GDG to agree evidence statements and recommendations. Additionally, in some areas formal consensus methods were used to identify current best practice as described above. A number of recommendations that underpin the suspicion of child maltreatment were formed through GDG consensus. These are based on principles of good clinical practice and form the basis upon which the clinical features section of the guidance rests. Shortly before the consultation period, the GDG members independently assessed all recommendations and group consensus was sought. The agreed draft recommendations were sent to two user reviewers for comment before the consultation phase.

The GDG also identified some areas where information that corresponded to the remit of this guidance was lacking and formulated recommendations for future research. From these recommendations, five key priorities for research were identified based on clinical need.

## **RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS**

Not applicable

## **COST ANALYSIS**

A formal cost analysis was not performed and published cost analyses were not reviewed.

## **METHOD OF GUIDELINE VALIDATION**

External Peer Review  
Internal Peer Review

## **DESCRIPTION OF METHOD OF GUIDELINE VALIDATION**

The guideline was validated through two consultations.

1. The first draft of the guideline (including the full guideline and Quick Reference Guide) was consulted with stakeholders and comments were considered by the Guideline Development Group (GDG).

2. The final consultation draft of the full guideline and the Information for the Public were submitted to stakeholders for final comments.

This guidance has been developed in accordance with the National Institute for Health and Clinical Excellence (NICE) guideline development process. This has included giving registered stakeholder organisations the opportunity to comment on the scope of the guidance at the initial stage of development and on the evidence and recommendations at the concluding stage. The developers have carefully considered all of the comments during the consultations by registered stakeholders and the validation by NICE.

## RECOMMENDATIONS

### MAJOR RECOMMENDATIONS

**Note from the National Guideline Clearinghouse (NGC):** This guideline was developed by the National Collaborating Centre for Women's and Children's Health (NCC-WCH) on behalf of the National Institute for Health and Clinical Excellence (NICE). See the "Availability of Companion Documents" field for the full version of this guidance.

#### **Definitions of Terms Used in This Guidance**

The alerting features in this guidance have been divided into two, according to the level of concern, with recommendations to either 'consider' or 'suspect' maltreatment.

##### **Consider**

For the purposes of this guidance, to consider child maltreatment means that maltreatment is one possible explanation for the alerting feature or is included in the differential diagnosis.

##### **Suspect**

For the purposes of this guidance, to suspect child maltreatment means a serious level of concern about the possibility of child maltreatment but is not proof of it.

##### **Unsuitable Explanation**

For the purposes of this guidance, an unsuitable explanation for an injury or presentation is one that is implausible, inadequate, or inconsistent:

- With the child or young person's
  - Presentation
  - Normal activities
  - Existing medical condition
  - Age or developmental stage
  - Account compared to that given by parent and carers
- Between parents or carers

- Between accounts over time

An explanation based on cultural practice is also unsuitable because this should not justify hurting a child or young person.

### **Using This Guidance**

If a healthcare professional encounters an alerting feature of possible child maltreatment that prompts them to consider, suspect, or exclude child maltreatment as a possible explanation, it is good practice to follow the process outlined in 1–5 below (see also Appendix C in the original guideline document):

#### **1. Listen and Observe**

Identifying or excluding child maltreatment involves piecing together information from many sources so that the whole picture of the child or young person is taken into account. This information may come from different sources and agencies and includes:

- Any history that is given
- Report of maltreatment, or disclosure from a child or young person or third party (Note: It is standard practice to refer to children's social services when a child or young person makes a disclosure of maltreatment [even though it may not be precise in every detail])
- Child's appearance
- Child's behaviour or demeanour
- Symptom
- Physical sign
- Result of an investigation
- Interaction between the parent or carer and child or young person

#### **2. Seek an Explanation**

Seek an explanation for any injury or presentation from both the parent or carer and the child or young person in an open and non-judgemental manner.

##### *Disability*

Alerting features of maltreatment in children with disabilities may also be features of the disability, making identification of maltreatment more difficult.

Healthcare professionals may need to seek appropriate expertise if they are concerned about a child or young person with a disability.

#### **3. Record**

- Record in the child or young person's clinical record exactly what is observed and heard from whom and when.
- Record why this is of concern.

At this point the healthcare professional may consider, suspect, or exclude child maltreatment from the differential diagnosis.

#### **4. Consider, Suspect or Exclude Maltreatment**

##### *Consider*

At any stage during the process of considering maltreatment the level of concern may change and lead to exclusion or suspicion of maltreatment.

When hearing about or observing an alerting feature in the guidance:

- Look for other alerting features of maltreatment in the child or young person's history, presentation or parent– or carer–interaction with the child or young person now or in the past.

Then do one or more of the following:

- Discuss your concerns with a more experienced colleague, a community paediatrician, child and adolescent mental health service colleague, or a named or designated professional for safeguarding children.
- Gather collateral information from other agencies and health disciplines, having used professional judgement about whether to explain the need to gather this information for an overall assessment of the child.
- Ensure review of the child or young person at a date appropriate to the concern, looking out for repeated presentations of this or any other alerting features.

##### *Suspect*

If an alerting feature or considering child maltreatment prompts a healthcare professional to suspect child maltreatment they should refer the child or young person to children's social care, following Local Safeguarding Children Board procedures.

This may trigger a child protection investigation, supportive services may be offered to the family following an assessment, or alternative explanations may be identified.

##### *Exclude*

Exclude maltreatment when a suitable explanation is found for alerting features. This may be the decision following discussion of the case with a more experienced colleague or after gathering collateral information as part of considering child maltreatment.

#### **5. Record**

Record all actions taken in 4 and the outcome.

## **Physical Features**

### **Bruises**

Suspect child maltreatment if a child or young person has bruising in the shape of a hand, ligature, stick, teeth mark, grip or implement.

Suspect child maltreatment if there is bruising or petechiae (tiny red or purple spots) that are not caused by a medical condition (for example, a causative coagulation disorder) and if the explanation for the bruising is unsuitable ("unsuitable" means implausible, inadequate, or inconsistent). Examples include:

- Bruising in a child who is not independently mobile
- Multiple bruises or bruises in clusters
- Bruises of a similar shape and size
- Bruises on any non-bony part of the body or face including the eyes, ears, and buttocks
- Bruises on the neck that look like attempted strangulation
- Bruises on the ankles and wrists that look like ligature marks

### **Bites**

Suspect child maltreatment if there is a report or appearance of a human bite mark that is thought unlikely to have been caused by a young child.

Consider neglect if there is a report or appearance of an animal bite on a child who has been inadequately supervised.

### **Lacerations (Cuts), Abrasions, and Scars**

Suspect child maltreatment if a child has lacerations, abrasions, or scars and the explanation is unsuitable. Examples include lacerations, abrasions, or scars:

- On a child who is not independently mobile
- That are multiple
- With a symmetrical distribution
- On areas usually protected by clothing (for example, back, chest, abdomen, axilla, genital area)
- On the eyes, ears, and sides of face
- On the neck, ankles, and wrists that look like ligature marks

### **Thermal Injuries**

Suspect child maltreatment if a child has burn or scald injuries:

- If the explanation for the injury is absent or unsuitable **or**
- If the child is not independently mobile **or**
- On any soft tissue area that would not be expected to come into contact with a hot object in an accident (for example, the backs of hands, soles of feet, buttocks, back) **or**
- In the shape of an implement (for example, cigarette, iron) **or**

- That indicate forced immersion, for example:
  - Scalds to buttocks, perineum, and lower limbs
  - Scalds to limbs in a glove or stocking distribution
  - Scalds to limbs with symmetrical distribution
  - Scalds with sharply delineated borders

### **Cold Injury**

Consider child maltreatment if a child has cold injuries (for example, swollen, red hands or feet) with no obvious medical explanation.

Consider child maltreatment if a child presents with hypothermia and the explanation is unsuitable.

### **Fractures**

Suspect child maltreatment if a child has one or more fractures in the absence of a medical condition that predisposes to fragile bones (for example, osteogenesis imperfecta, osteopenia of prematurity) or if the explanation is absent or unsuitable. Presentations include:

- Fractures of different ages
- X-ray evidence of occult fractures (fractures identified on X-rays that were not clinically evident), for example, rib fractures in infants

### **Intracranial Injuries**

Suspect child maltreatment if a child has an intracranial injury in the absence of major confirmed accidental trauma or known medical cause, in one or more of the following circumstances:

- The explanation is absent or unsuitable
- The child is aged under 3 years
- There are also:
  - Retinal hemorrhages **or**
  - Rib or long bone fractures **or**
  - Other associated inflicted injuries
- There are multiple subdural haemorrhages with or without subarachnoid haemorrhage with or without hypoxic ischaemic damage (damage due to lack of blood and oxygen supply) to the brain.

### **Eye Trauma**

Suspect child maltreatment if a child has retinal haemorrhages or injury to the eye in the absence of major confirmed accidental trauma or a known medical explanation, including birth-related causes.

### **Spinal Injuries**

Suspect physical abuse if a child presents with signs of a spinal injury (injury to vertebrae or within the spinal canal) in the absence of major confirmed accidental trauma. Spinal injury may present as:

- A finding on skeletal survey or magnetic resonance imaging
- Cervical injury in association with inflicted head injury
- Thoracolumbar injury in association with focal neurology or unexplained kyphosis (curvature or deformity of the spine)

### **Visceral Injuries**

Suspect child maltreatment if a child has an intra-abdominal or intrathoracic injury in the absence of major confirmed accidental trauma and there is an absent or unsuitable explanation, or a delay in presentation. There may be no external bruising or other injury.

### **Oral Injury**

Consider child maltreatment if a child has an oral injury and the explanation is absent or unsuitable.

### **General Injuries**

Consider child maltreatment if there is no suitable explanation for a serious or unusual injury.

### **Anogenital Signs and Symptoms**

Suspect sexual abuse if a girl or boy has a genital, anal, or perianal injury (as evidenced by bruising, laceration, swelling, or abrasion) and the explanation is absent or unsuitable.

Suspect sexual abuse if a girl or boy has a persistent or recurrent genital or anal symptom (for example, bleeding or discharge) that is associated with behavioural or emotional change and that has no medical explanation.

Suspect sexual abuse if a girl or boy has an anal fissure, and constipation, Crohn's disease, and passing hard stools have been excluded as the cause.

Consider sexual abuse if a gaping anus in a girl or boy is observed during an examination and there is no medical explanation (for example, a neurological disorder or severe constipation).

Consider sexual abuse if a girl or boy has a genital or anal symptom (for example, bleeding or discharge) without a medical explanation.

Consider sexual abuse if a girl or boy has dysuria (discomfort on passing urine) or ano-genital discomfort that is persistent or recurrent and does not have a medical explanation (for example, worms, urinary infection, skin conditions, poor hygiene or known allergies).

Consider sexual abuse if there is evidence of one or more foreign bodies in the vagina or anus. Foreign bodies in the vagina may be indicated by offensive vaginal discharge.

### **Sexually Transmitted Infections**

Consider sexual abuse if a child younger than 13 years has hepatitis B unless there is clear evidence of mother-to-child transmission during birth, non-sexual transmission from a member of the household, or blood contamination.

Consider sexual abuse if a child younger than 13 years has anogenital warts unless there is clear evidence of mother-to-child transmission during birth or non-sexual transmission from a member of the household.

Suspect sexual abuse if a child younger than 13 years has gonorrhoea, chlamydia, syphilis, genital herpes, hepatitis C, human immunodeficiency virus (HIV), or trichomonas infection unless there is clear evidence of mother-to-child transmission during birth or blood contamination.

Consider sexual abuse if a young person aged 13 to 15 years has hepatitis B unless there is clear evidence of mother-to-child transmission during birth, non-sexual transmission from a member of the household, blood contamination, or that the infection was acquired from consensual sexual activity with a peer.

Consider sexual abuse if a young person aged 13 to 15 years has anogenital warts unless there is clear evidence of mother-to-child transmission during birth, non-sexual transmission from a member of the household, or that the infection was acquired from consensual sexual activity with a peer.

Consider sexual abuse if a young person aged 13 to 15 years has gonorrhoea, chlamydia, syphilis, genital herpes, hepatitis C, HIV, or trichomonas infection unless there is clear evidence of mother-to-child transmission during birth, blood contamination, or that the sexually transmitted infection (STI) was acquired from consensual sexual activity with a peer. (Note: In these circumstances, consider discussion of your concerns with a named or designated professional for safeguarding children.)

Consider sexual abuse if a young person aged 16 or 17 years has hepatitis B and there is:

- No clear evidence of mother-to-child transmission during birth, non-sexual transmission from a member of the household, blood contamination, or that the infection was acquired from consensual sexual activity **and**
- A clear difference in power or mental capacity between the young person and their sexual partner, in particular when the relationship is incestuous or is with a person in a position of trust (for example, teacher, sports coach, minister of religion) **or**
- Concern that the young person is being exploited

Consider sexual abuse if a young person aged 16 or 17 years has anogenital warts and there is:

- No clear evidence of non-sexual transmission from a member of the household or that the infection was acquired from consensual sexual activity **and**
- A clear difference in power or mental capacity between the young person and their sexual partner, in particular when the relationship is incestuous or is with a person in a position of trust (for example, teacher, sports coach, minister of religion) **or**
- Concern that the young person is being exploited

Consider sexual abuse if a young person aged 16 or 17 years has gonorrhoea, chlamydia, syphilis, genital herpes, hepatitis C, HIV, or trichomonas infection and there is:

- No clear evidence of blood contamination or that the STI was acquired from consensual sexual activity **and**
- A clear difference in power or mental capacity between the young person and their sexual partner, in particular when the relationship is incestuous or is with a person in a position of trust (for example, teacher, sports coach, minister of religion) **or**
- Concern that the young person is being exploited

### **Clinical Presentations**

#### **Pregnancy**

Be aware that sexual intercourse with a child younger than 13 years is unlawful and therefore pregnancy in such a child means the child has been maltreated.

Consider sexual abuse if a young woman aged 13 to 15 years is pregnant.

Consider sexual abuse if a young woman aged 16 or 17 years is pregnant and there is:

- A clear difference in power or mental capacity between the young woman and the putative father, in particular when the relationship is incestuous or is with a person in a position of trust (for example, teacher, sports coach, minister of religion) **or**
- Concern that the young woman is being exploited **or**
- Concern that the sexual activity was not consensual

#### **Apparent Life-threatening Event**

Suspect child maltreatment if a child has repeated apparent life-threatening events, the onset is witnessed only by one parent or carer, and a medical explanation has not been identified.

Consider child maltreatment if an infant has an apparent life-threatening event with bleeding from the nose or mouth and a medical explanation has not been identified.

#### **Poisoning**

Suspect child maltreatment in cases of poisoning in children if:

- There is a report of deliberate administration of inappropriate substances, including prescribed and non-prescribed drugs **or**
- There are unexpected blood levels of drugs not prescribed for the child
- There is reported or biochemical evidence of ingestions of one or more toxic substance **or**
- The child was unable to access the substance independently **or**
- The explanation for the poisoning or how the substance came to be in the child is absent **or** unsuitable\*
- There have been repeated presentations of ingestions in the child or other children in the household

Consider child maltreatment in cases of hypernatraemia (abnormally high levels of sodium in the blood) and a medical explanation has not been identified.

### **Non-fatal Submersion Injury**

Suspect child maltreatment if a child has a non-fatal submersion incident (near-drowning) and the explanation is absent or unsuitable\* or if the child's presentation is inconsistent with the account.

Consider child maltreatment if a non-fatal submersion incident suggests a lack of supervision.

### **Attendance at Medical Services**

Consider child maltreatment if there is an unusual pattern of presentation to and contact with healthcare providers, or there are frequent presentations or reports of injuries.

### **Fabricated or Induced Illness**

Consider fabricated or induced illness if a child's history, physical or psychological presentations or findings of assessments, examinations, or investigations leads to a discrepancy with a recognised clinical picture. Fabricated or induced illness is a possible explanation even if the child has a past or concurrent physical or psychological condition.

Suspect fabricated or induced illness if a child's history, physical or psychological presentations or findings of assessments, examinations, or investigations leads to a discrepancy with a recognised clinical picture and one or more of the following is present:

- Reported symptoms and signs only appear or reappear when the parent or carer is present.
- Reported symptoms are only observed by the parent or carer.
- An inexplicably poor response to prescribed medication or other treatment.
- New symptoms are reported as soon as previous ones have resolved.

- There is a history of events that is biologically unlikely (for example, infants with a history of very large blood losses who do not become unwell or anaemic).
- Despite a definitive clinical opinion being reached, multiple opinions from both primary and secondary care are sought and disputed by the parent or carer and the child continues to be presented for investigation and treatment with a range of signs and symptoms.
- The child's normal daily activities (for example, school attendance) are being compromised, or the child is using aids to daily living (for example, wheelchairs) more than would be expected for any medical condition that the child has.

Fabricated or induced illness is a likely explanation even if the child has a past or concurrent physical or psychological condition.

### **Inappropriately Explained Poor School Attendance**

Consider child maltreatment if a child has poor school attendance that the parents or carers know about that has no justification on health, including mental health, grounds and home education is not being provided.

### **Neglect – Failure of Provision and Failure of Supervision**

Neglect is a situation involving risk to the child or young person. It is the persistent failure to meet the child or young person's basic physical or psychological needs that is likely to result in the serious impairment of their health or development. This may or may not be deliberate. There are differences in how parents and carers choose to raise their children, including the choices they make about their children's healthcare. However, failure to recognise and respond to the child or young person's needs may amount to neglect.

There is no diagnostic gold standard for neglect and therefore decision-making in situations of apparent neglect can be very difficult and thresholds hard to establish. It is essential to place the child or young person at the centre of the assessment.

### **Provision of Basic Needs**

Consider neglect if a child has severe and persistent infestations, such as scabies or head lice.

Consider neglect if a child's clothing or footwear is consistently inappropriate (for example, for the weather or the child's size).

Instances of inadequate clothing that have a suitable explanation (for example, a sudden change in the weather, slippers worn because they were closest to hand when leaving the house in a rush) would not be alerting features for possible neglect.

Suspect neglect if a child is persistently smelly and dirty.

Children often become dirty and smelly during the course of the day. However, the nature of the child's smell may be so overwhelming that the possibility of persistent lack of provision or care should be taken into account. Examples include:

- Child seen at times of the day when it is unlikely that they would have had an opportunity to become dirty or smelly (for example, an early morning visit)
- If the dirtiness is ingrained

Suspect neglect if you repeatedly observe or hear reports of the following home environment that is in the parents' or carers' control:

- A poor standard of hygiene that affects a child's health
- Inadequate provision of food
- A living environment that is unsafe for the child's developmental stage

It may be difficult to distinguish between neglect and material poverty. However, care should be taken to balance recognition of the constraints on the parents' or carers' ability to meet their children's needs for food, clothing, and shelter with an appreciation of how people in similar circumstances have been able to meet those needs.

Be aware that abandoning a child is a form of maltreatment.

### **Malnutrition**

Consider neglect if a child displays faltering growth (failure to thrive) because of lack of provision of an adequate or appropriate diet.

### **Supervision**

Achieving a balance between an awareness of risk and allowing children freedom to learn by experience can be difficult. However, if parents or carers persistently fail to anticipate dangers and to take precautions to protect their child from harm it may constitute neglect.

Consider neglect if the explanation for an injury (for example, a burn, sunburn, or an ingestion of a harmful substance) suggests a lack of appropriate supervision.

Consider neglect if a child or young person is not being cared for by a person who is able to provide adequate care.

### **Ensuring Access to Appropriate Medical Care or Treatment**

Consider neglect if parents or carers fail to administer essential prescribed treatment for their child.

Consider neglect if parents or carers repeatedly fail to attend essential follow-up appointments that are necessary for their child's health and well being.

Consider neglect if parents or carers persistently fail to engage with relevant child health promotion programmes which include:

- Immunisation
- Health and development reviews
- Screening

Consider neglect if parents or carers have access to but persistently fail to obtain National Health Service (NHS) treatment for their child's dental caries (tooth decay).

Suspect neglect if parents or carers fail to seek medical advice for their child to the extent that the child's health and well being is compromised, including if the child is in ongoing pain.

### **Emotional, Behavioural, Interpersonal, and Social Functioning**

#### **Emotional and Behavioural States**

Consider child maltreatment if a child or young person displays or is reported to display a marked change in behaviour or emotional state (see examples below) that is a departure from what would be expected for their age and developmental stage and is not explained by a known stressful situation that is not part of child maltreatment (for example, bereavement or parental separation) or medical cause. Examples include:

- Recurrent nightmares containing similar themes
- Extreme distress
- Markedly oppositional behaviour
- Withdrawal of communication
- Becoming withdrawn

Consider child maltreatment if a child's behaviour or emotional state is not consistent with their age and developmental stage or cannot be explained by medical causes, neurodevelopmental disorders (for example, attention deficit hyperactivity disorder [ADHD], autism spectrum disorders), or other stressful situation that is not part of child maltreatment (for example, bereavement or parental separation). Examples of behaviour or emotional states that may fit this description include:

- Emotional states:
  - Fearful, withdrawn, low self-esteem
- Behaviour:
  - Aggressive, oppositional
  - Habitual body rocking
- Interpersonal behaviours:
  - Indiscriminate contact or affection seeking
  - Over-friendliness to strangers including healthcare professionals
  - Excessive clinginess
  - Persistently resorting to gaining attention

- Demonstrating excessively 'good' behaviour to prevent parental or carer disapproval
- Failing to seek or accept appropriate comfort or affection from an appropriate person when significantly distressed
- Coercive controlling behaviour towards parents or carers
- Very young children showing excessive comforting behaviours when witnessing parental or carer distress

Consider child maltreatment if a child shows repeated, extreme, or sustained emotional responses that are out of proportion to a situation and are not expected for the child's age or developmental stage or explained by a medical cause, neurodevelopmental disorder (for example, ADHD, autism spectrum disorders), or bipolar disorder and the effects of any known past maltreatment have been explored. Examples of these emotional responses include:

- Anger or frustration expressed as a temper tantrum in a school-aged child
- Frequent rages at minor provocation
- Distress expressed as inconsolable crying

Consider child maltreatment if a child shows dissociation (transient episodes of detachment that are outside the child's control and that are distinguished from daydreaming, seizures, or deliberate avoidance of interaction) that is not explained by a known traumatic event unrelated to maltreatment.

Consider child maltreatment if a child or young person regularly has responsibilities that interfere with essential normal daily activities (for example, school attendance).

Consider child maltreatment if a child responds to a health examination or assessment in an unusual, unexpected, or developmentally inappropriate way (for example, extreme passivity, resistance, or refusal).

## **Behavioural Disorders or Abnormalities Either Seen or Heard About**

### *Self-harm*

Consider past or current child maltreatment, particularly sexual, physical, or emotional abuse, if a child or young person is deliberately self-harming. Self-harm includes cutting, scratching, picking, biting, or tearing skin to cause injury, pulling out hair or eyelashes, and deliberately taking prescribed or non-prescribed drugs at higher than therapeutic doses.

### *Disturbances in Eating and Feeding Behaviour*

Suspect child maltreatment if a child repeatedly scavenges, steals, hoards, or hides food with no medical explanation.

### *Wetting and Soiling*

Consider child maltreatment if a child has secondary day- or night-time wetting that persists despite adequate assessment and management unless there is a

medical explanation (for example, urinary tract infection) or clearly identified stressful situation that is not part of maltreatment (for example, bereavement, parental separation).

Consider child maltreatment if a child is reported to be deliberately wetting.

Consider child maltreatment if a child shows encopresis (repeatedly defecating a normal stool in an inappropriate place) or repeated, deliberate smearing of faeces.

### *Sexualised Behaviour*

Suspect child maltreatment, and in particular sexual abuse, if a pre-pubertal child displays or is reported to display repeated or coercive sexualised behaviours or preoccupation (for example, sexual talk associated with knowledge, drawing genitalia, emulating sexual activity with another child).

Suspect past or current child maltreatment if a child or young person's sexual behaviour is indiscriminate, precocious, or coercive.

Suspect sexual abuse if a pre-pubertal child displays or is reported to display unusual sexualised behaviours. Examples include:

- Oral-genital contact with another child or a doll
- Requesting to be touched in the genital area
- Inserting or attempting to insert an object, finger, or penis into another child's vagina or anus

### *Runaway Behaviour*

Consider child maltreatment if a child or young person has run away from home or care, or is living in alternative accommodation without the full agreement of their parents or carers.

## **Parent-Child Interactions**

Consider emotional abuse if there is concern that parent- or carer-child interactions may be harmful. Examples include:

- Negativity or hostility towards a child or young person
- Rejection or scapegoating of a child or young person
- Developmentally inappropriate expectations of or interactions with a child, including inappropriate threats or methods of disciplining
- Exposure to frightening or traumatic experiences, including domestic abuse
- Using the child for the fulfilment of the adult's needs (for example, children being used in marital disputes)
- Failure to promote the child's appropriate socialisation (for example, involving children in unlawful activities, isolation, not providing stimulation or education)

Suspect emotional abuse when persistent harmful parent- or carer-child interactions are observed or reported.

Consider child maltreatment if parents or carers are seen or reported to punish a child for wetting despite professional advice that the symptom is involuntary.

Consider emotional neglect if there is emotional unavailability and unresponsiveness from the parent or carer towards a child and in particular towards an infant.

Suspect emotional neglect if there is persistent emotional unavailability and unresponsiveness from the parent or carer towards a child and in particular towards an infant.

Consider child maltreatment if a parent or carer refuses to allow a child or young person to speak to a healthcare professional on their own when it is necessary for the assessment of the child or young person.

### **CLINICAL ALGORITHM(S)**

Appendix C of the original guideline document includes a clinical algorithm, 'Using this guidance', which outlines the process of encountering child maltreatment.

## **EVIDENCE SUPPORTING THE RECOMMENDATIONS**

### **TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS**

Recommendations are based on clinical evidence, and where this is insufficient, the Guideline Development Group (GDG) used all available information sources and experience to make consensus recommendations.

## **BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS**

### **POTENTIAL BENEFITS**

Improved awareness among healthcare professionals in identification of children who may be maltreated

### **POTENTIAL HARMS**

Not stated

## **QUALIFYING STATEMENTS**

### **QUALIFYING STATEMENTS**

This guidance represents the view of the National Institute for Health and Clinical Excellence (NICE), which was arrived at after careful consideration of the evidence available. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. However, the guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient

and/or guardian or carer, and informed by the summary of product characteristics of any drugs they are considering.

Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of opportunity. Nothing in this guidance should be interpreted in a way that would be inconsistent with compliance with those duties.

## **Understanding the Obstacles to Recognising Maltreatment**

There are obstacles among healthcare professionals to recognising child maltreatment and to accepting that child maltreatment commonly occurs. Some of these obstacles relate to the healthcare practitioners' professional and personal experiences (including maltreatment) or lack of training. Other obstacles include the following:

- Concern about missing a treatable disorder
- Healthcare professionals are used to working with parents and carers in the care of children and fear losing the positive relationship with a family already under their care.
- Discomfort of disbelieving, thinking ill of, suspecting, or wrongly blaming a parent or carer
- Divided duties to adult and child patients and breaching confidentiality
- Understanding the background and reasons why the maltreatment might have occurred, especially when there is no perceived intention to harm the child
- Difficulty in saying that a presentation is unclear and there is uncertainty about whether the presentation really indicates significant harm
- Uncertainty about when to mention suspicion, what to say to parent(s) or carer(s), and what to write in the clinical file
- Losing control over the child protection process and doubts about its benefits
- Child protection processes can be stressful for professionals and time-consuming.
- Personal safety
- Fear of complaints, litigation, and dealings with professional bodies
- Fear of seeking support from colleagues

## **IMPLEMENTATION OF THE GUIDELINE**

### **DESCRIPTION OF IMPLEMENTATION STRATEGY**

The Healthcare Commission assesses the performance of National Health Service (NHS) organisations in meeting core and developmental standards set by the Department of Health in 'Standards for better health' (available from [www.dh.gov.uk](http://www.dh.gov.uk)). Implementation of clinical guidelines forms part of the developmental standard D2. Core standard C5 says that national agreed guidance should be taken into account when NHS organisations are planning and delivering care.

National Institute for Health and Clinical Excellence (NICE) has developed tools to help organisations implement this guidance (listed below). These are available on the NICE website (<http://guidance.nice.org.uk/CG89>; see also the "Availability of Companion Documents" field):

- Slides highlighting key messages for local discussion
- Costing statement
- Audit support for monitoring local practice

## **IMPLEMENTATION TOOLS**

Audit Criteria/Indicators  
Clinical Algorithm  
Foreign Language Translations  
Patient Resources  
Quick Reference Guides/Physician Guides  
Resources  
Slide Presentation  
Staff Training/Competency Material

For information about [availability](#), see the "Availability of Companion Documents" and "Patient Resources" fields below.

## **INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES**

### **IOM CARE NEED**

Getting Better  
Staying Healthy

### **IOM DOMAIN**

Effectiveness  
Patient-centeredness

## **IDENTIFYING INFORMATION AND AVAILABILITY**

### **BIBLIOGRAPHIC SOURCE(S)**

National Collaborating Centre for Women's and Children's Health. When to suspect child maltreatment. London (UK): National Institute for Health and Clinical Excellence (NICE); 2009 Dec. 40 p. (Clinical guideline; no. 89).

### **ADAPTATION**

Not applicable: The guideline was not adapted from another source.

### **DATE RELEASED**

2009 Dec

## **GUIDELINE DEVELOPER(S)**

National Collaborating Centre for Women's and Children's Health - National Government Agency [Non-U.S.]

## **SOURCE(S) OF FUNDING**

National Institute for Health and Clinical Excellence (NICE)

## **GUIDELINE COMMITTEE**

Guideline Development Group

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## **FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST**

All Guideline Development Group (GDG) members' interests were recorded on declaration forms provided by the National Institute for Health and Clinical Excellence (NICE). The form covered consultancies, fee-paid work, shareholdings, fellowships, and support from the healthcare industry. GDG members' interests are listed in Appendix A of the full version of the original guideline. No material conflicts of interest were identified.

## **GUIDELINE STATUS**

This is the current release of the guideline.

## **GUIDELINE AVAILABILITY**

Electronic copies: Available in Portable Document Format (PDF) format from the [National Institute for Health and Clinical Excellence \(NICE\) Web site](#).

## **AVAILABILITY OF COMPANION DOCUMENTS**

The following are available:

- When to suspect child maltreatment. Full guideline. London (UK): National Institute for Health and Clinical Excellence (NICE); 2009 Dec. 148 p. (Clinical guideline; no. 89). Electronic copies: Available in Portable Document Format (PDF) format from the [National Institute for Health and Clinical Excellence \(NICE\) Web site](#).
- When to suspect child maltreatment. Evidence tables. London (UK): National Institute for Health and Clinical Excellence (NICE); 2009 Jul. 82 p. (Clinical guideline; no. 89). Electronic copies: Available in Portable Document Format (PDF) format from the [NICE Web site](#).
- When to suspect child maltreatment. Search strategies. London (UK): National Institute for Health and Clinical Excellence (NICE); 2009 Jul. 304 p. (Clinical guideline; no. 89). Electronic copies: Available in Portable Document Format (PDF) format from the [NICE Web site](#).
- When to suspect child maltreatment. Excluded studies. London (UK): National Institute for Health and Clinical Excellence (NICE); 2009 Jul. 100 p. (Clinical guideline; no. 89). Electronic copies: Available in Portable Document Format (PDF) format from the [NICE Web site](#).

- When to suspect child maltreatment. Slide set. London (UK): National Institute for Health and Clinical Excellence (NICE); 2009 Aug. 25 p. (Clinical guideline; no. 89). Electronic copies: Available from the [NICE Web site](#).
- When to suspect child maltreatment. Quick reference guide. London (UK): National Institute for Health and Clinical Excellence; 2009 Dec. 18 p. (Clinical guideline; no. 89). Electronic copies: Available in Portable Document Format (PDF) from the [NICE Web site](#).
- When to suspect child maltreatment. Costing statement. London (UK): National Institute for Health and Clinical Excellence (NICE); 2009 Jul. 6 p. (Clinical guideline; no. 89). Electronic copies: Available in Portable Document Format (PDF) format from the [NICE Web site](#).
- When to suspect child maltreatment. Audit support. London (UK): National Institute for Health and Clinical Excellence; 2009 Sep. 9 p. (Clinical guideline; no. 89). Electronic copies: Available from the [NICE Web site](#).
- When to suspect child maltreatment. Training slide set. London (UK): National Institute for Health and Clinical Excellence (NICE); 2009 Oct. 37 p. (Clinical guideline; no. 89). Electronic copies: Available from the [NICE Web site](#).
- When to suspect child maltreatment. Training plan. London (UK): National Institute for Health and Clinical Excellence (NICE); 2009 Dec. 8 p. (Clinical guideline; no. 89). Electronic copies: Available from the [NICE Web site](#).
- When to suspect child maltreatment. Online educational tool. London (UK): National Institute for Health and Clinical Excellence; 2009. Various p. (Clinical guideline; no. 89). Electronic copies: Available from the [NICE Web site](#).
- The guidelines manual 2009. London (UK): National Institute for Health and Clinical Excellence (NICE); 2009. Electronic copies: Available in Portable Document Format (PDF) from the [NICE Web site](#).

Print copies: Phone NICE publications on 0845 003 7783. ref: N1900. 11 Strand, London, WC2N 5HR.

## **PATIENT RESOURCES**

The following is available:

- When to suspect child maltreatment: Understanding NICE guidance - Information for people who use NHS services. London (UK): National Institute for Health and Clinical Excellence; 2009. Various p. (Clinical guideline; no. 89). Electronic copies: Available in [English](#) and [Welsh](#) in Portable Document Format (PDF) from the National Institute for Health and Clinical Excellence (NICE) Web site.

Print copies: Phone NICE publications on 0845 033 7783. ref: N1901. 11 Strand, London, WC2N 5HR.

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

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